IPDR6702				NORTH CAROLINA		PA	GE: 1	
	: 09/09/2007			RS CHECKWRITE SUMMARY REPORT				
				CHECKWRITE DATE: 09/11/2007				
			1	FINANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS FINALIZED	CLAIMS
NOMBER	PROVIDER NAME	EOBS	DENTALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	8505	73	CLAIM DENIED DUE TO INSUFFICIE				
	H/DD/SAS			NT BUDGET				
		79	69	THIS SERVICE IS NOT PAYABLE TO	0	219	262	43
				YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
				PROVIDER TIPE AND SPECIABIT IN				
		8800	68	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
				101002 101 01				
3404904	WESTERN HIGHLAN	3411	1213	PROVIDER TYPE AND SPECIALTY 07				
	DS LME			4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D				
		3412	532	PROVIDER TYPE AND SPECIALTY 07	(	2109	3488	1379
			1	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D				
			+	January on on Alland				
		5404	130	SEVERE DUPLICATE: SAME ATTD PR				
			1	OV/PCODE/TOS/DOS/MOD	_			
3404910	PATHWAYS	11	69	CLIENT NOT ELIGIBLE ON SERVICE				
			1	DATE	_			
		5308	31	PRIOR AUTHORIZED UNITS EXCEEDE	3	. 139	4394	4125
				D				
		8599	13	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				DAME IT PROPERTY.				
3404912	CATAWBA COUNTYM	8536	166	ATTENDING PROVIDER TYPE AND SP				
	ENTAL HEALT			ECIALTY COMBINATION IS NOT  VALID FOR SUBMITTED BILLING PR				
				VALUE FOR GODALITED DIEDLING IX				
		8505	2	CLAIM DENIED DUE TO INSUFFICIE	(	171	425	254
				NT BUDGET				
		191	2	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404913	MECKLENBURG COM	8505	9912	CLAIM DENIED DUE TO INSUFFICIE				
	ENTAL HEALT			NT BUDGET				
		8800	1566	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON		11499	11568	69
				FUTURE RA'S.				
		8599	17	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND				
			+	BENEFIT PACKAGE.				
2404025		0505	22	ALVAN DENVED DIE 400 ANOMAN				
3404916	CROSSROADS BEHA VIORAL HEAL	8505	23	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET				
	JORNI HANDI			-				
		9999	12	BURNING DOGGGGANG MICCOCCA				
		8800	12	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON		42	605	563
				FUTURE RA'S.				
		70		WILLY CHRISTON TO NOW DANGED TO		1		
		79	3	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
2404917		9500	104	DETAIL NOT COVERED BY COMBINAT				
3404917	CENTERPOINT HUM AN SERVICES	8599	104	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND				
	OBEVICES			BENEFIT PACKAGE.			1	
		0505	0.4	CULTU DENTED DUE DO THOUSEN				
		8505	84	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET		302	6259	5957
		9900	A E	DIDTUPD DDOORCOING NEGROUARY				
		8800	45	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON				

PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL CLAIMS	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919		0505	0.740	CLAIM DENIED DUE TO INSUFFICIE				
3404919	GUILFORD CO MEN TAL HEALTHC	8505	8340	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET				
	TAL HEADING							
			1440					
		8800	1448	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	(	10007	10428	421
				FUTURE RA'S.				
		8599	120	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
2404000		0.7	22	DUPLICATE OF CLAIM-SYSTEM				
3404920	ALAMANCE CASWEL L AREA MH D	21	31	DUPLICATE OF CLAIM-SYSTEM				
	D PAGES PAIR D							
		5404	11	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD	(	48	328	280
		79	6	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404921	ORANGE PERSON C	11	720	CLIENT NOT ELIGIBLE ON SERVICE DATE	<u> </u>			
	HATHAM AREA			arran air	+			
		1						
		8535	6	SERVICE FACILITY LOCATION WAS		746	1835	1089
				NOT SUBMITTED ON THIS CLAIM.  PLEASE RESUBMIT THE CLAIM WITH	-			
					<del> </del>			
		120	5	CLIENT ID NUMBER MISSING OR IN				
				VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				
				AS A NEW CURIN				
3404922	THE DURHAM CENT	23	1	SERVICE REQUIRES PRIOR APPROVA				
	ER			L				
		0	0		(	1	1	0
3404923		8505	2017	CLAIM DENIED DUE TO INSUFFICIE				
3101923	FIVE COUNTY MH	6303	2017	NT BUDGET				
			000					
		8800	296	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	(	2439	2945	506
				FUTURE RA'S.				
		11	76	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404925	SANDHILLS CENTE	8505	5870	CLAIM DENIED DUE TO INSUFFICIE				
	R FOR MH/DD			NT BUDGET				
		8800	823	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	8	6766	6987	221
				FUTURE RA'S.				
				1				
		191	26	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME	-			
				1				
3404926	SOUTHEASTERN RE	8800	174	FURTHER PROCESSING NECESSARY,				
	G MENTAL HL			PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	-			
					1			
		8599	33	DETAIL NOT COVERED BY COMBINAT	1	. 327	2461	2125
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	<u> </u>			
			1	DENELLI PACAMOR.	it.	1		
								1
		23	30	SERVICE REQUIRES PRIOR APPROVA				
		23	30					
		23	30					
3404927	CUMBERLAND CO M	23	30					
3404927	CUMBERLAND CO M			SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
3404927				SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT				
3404927				SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND		15.	15.47	1205
3404927		8599	109	SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.		) 151	1547	1396
3404927		8599	109	SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT NOT ELIGIBLE ON SERVICE	C	151	1547	1396
3404927		8599	109	SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT NOT ELIGIBLE ON SERVICE DATE	C	151	1547	1396
3404927		8599	109	SERVICE REQUIRES PRIOR APPROVA L DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLIENT NOT ELIGIBLE ON SERVICE	(	151	1547	1396

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404930	JOHNSTON COUNTY	0	0	*** NO DATA TO REPORT ***				
	MNTL HLTHC							
		0	0			0	0	
							0	
3404931	WAKE CO HUM SVC	21	151	DUPLICATE OF CLAIM-SYSTEM				
	BILLING OF							
		8599	69	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND	15	513	3793	3280
				BENEFIT PACKAGE.				
		8536	64	ATTENDING PROVIDER TYPE AND SP				
				ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR				
3404933	SOUTHEASTERN CT	8599	12	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD			ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFIT FACAME.				
		191	11	CLIENT ID NUMBER DOES NOT MATC	0	36	270	234
				H PATIENT NAME				$\perp$
			-					-
		8537	4	PROCEDURE IS NOT PAYABLE FOR Y				
				OUR PROVIDER TYPE AND				
				SPECIALTY IN ACCORDANCE TO MEN				
3404934	ONSLOW CARTERET	8535	865	SERVICE FACILITY LOCATION WAS				1
	BEHAV HEAL			NOT SUBMITTED ON THIS CLAIM.	1			
				PLEASE RESUBMIT THE CLAIM WITH				
		21	211	DUPLICATE OF CLAIM-SYSTEM		1561	3329	1768
					0	1301	3329	1/00
		8536	97	ATTENDING PROVIDER TYPE AND SP				
		8530	37	ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR							
		0	0		0	0	0	0
3404936	THE BEACON CENT	0	0	*** NO DATA TO REPORT ***				
	ER							
		0	0		0	0	0	0
3404937		21	56	DUPLICATE OF CLAIM-SYSTEM				
3101937	THE BEACON CENT	21	50	BOFBICATE OF CHAIN-SISIEM				
		9500	10	DETAIL NOT COURDED BY COMPANY				
		8599	10	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	0	71	2507	2436
				BENEFIT PACKAGE.				
	-	0000		NO DATE MANYANYE ON THE STATE OF				
		8000	3	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL	1			
								-
2404		0500	153					
3404939	EAST CAROLINA B	8599	151	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1			<del> </del>
	EHAVIORAL H			BENEFIT PACKAGE.	1			<del>                                     </del>
	<u> </u>	21	126	DUPLICATE OF CLAIM-SYSTEM	0	445	2777	2332
								1
		7001	38	EXCEEDS THE ONE PER DAY LIMITA				
			-	TION	-	-		1
					1			1
3404941	EAST CAROLINA B	0	0	*** NO DATA TO REPORT ***				
_	EHAVIORAL H	<u> </u>			1			
					1			
		0	0		0	0	0	0
2404040		0	0	*** MO DATA TO DEPORT ***				
3404942	EAST CAROLINA B EHAVIORAL H	o .		*** NO DATA TO REPORT ***				-
	ENAVIURAL fi				1			-
		0	0		0	0	0	0
	1	1	L	1	1	1	1	

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404943	ALBEMARLE MENTA	11	23	CLIENT NOT ELIGIBLE ON SERVICE				
	L HEALTH CE			DATE				
		3411	23	PROVIDER TYPE AND SPECIALTY 07		89	1071	. 982
				4/113 CANNOT BILL ENHANCED				
				BENEFIT SERVICES ON OR AFTER D				
		8535	9	SERVICE FACILITY LOCATION WAS				
				NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
3404944	EASTPOINTE HUMA	21	2	DUPLICATE OF CLAIM-SYSTEM				
	N SERVICES							
		8654	2	ONLY 16 UNITS ALLOWED PER DAY		9	4126	4086
				WITHOUT PRIOR				
				APPROVAL. PLEASE CORRECT THE				
		8599	2	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404946	FOOTHILLS AREAM	21	1592	DUPLICATE OF CLAIM-SYSTEM				
	ENTAL HEALT							
		8532	232	SUBMITTED BILLING PROVIDER IS		1839	2030	191
				NOT ELIGIBLE FOR DATE OF				
				SERVICE BILLED				
						1		
		27	15	DIAGNOSIS CODE MISSING OR INVA				
				LID. VERIFY AND ENTER THE				
	T			CORRECT DIAGNOSIS CODE AND SUB				